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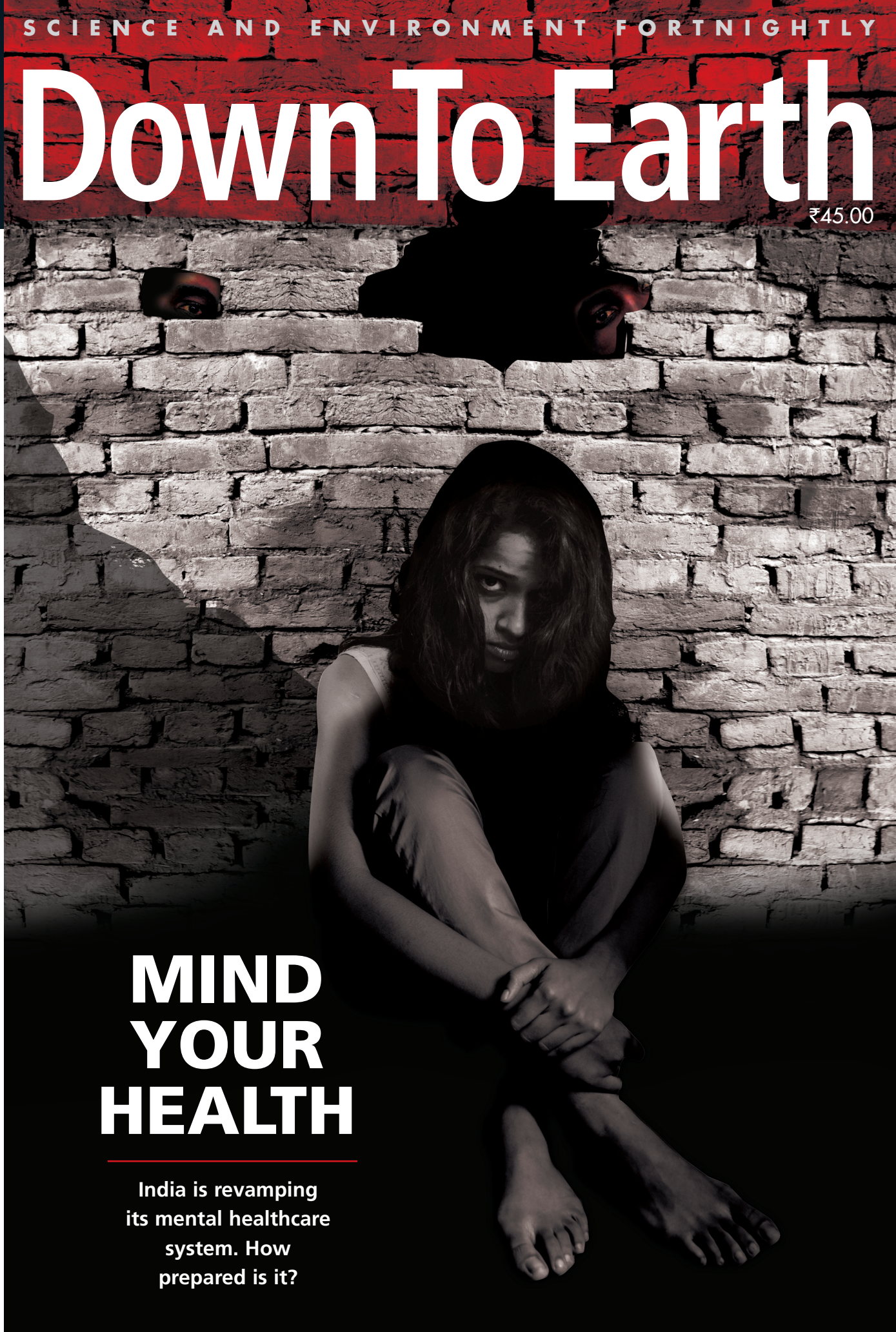

MIND YOUR HEALTH

India is revamping its mental healthcare system. How prepared is it?

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COVER STORY

TROUBLED BEAUTIFUL MINDS

THEY ARE THERE—EACH RESIDENTIAL AREA HAS ITS MENTALLY DISTURBED PEOPLE; EACH FAMILY HAS ANECDOTES OF CRAZY RELATIVES. NOBODY WANTS TO ACKNOWLEDGE THEM. AS PRESSURES OF LIFE GROW, SO DO TROUBLES OF THE MIND.

GOVERNMENTS WORLD-WIDE ARE LOOKING FOR WAYS TO TACKLE MENTAL ILLNESS THAT POSES THE SECOND MOST THREAT TO GLOBAL ECONOMY. INDIA HAS A NATIONAL PROGRAMME IN PLACE TO TACKLE THE PROBLEM FOR MORE THAN THREE DECADES BUT IT HAS FAILED TO DELIVER. NOW, TO IMPROVE THE SITUATION THE GOVERNMENT HAS DRAFTED A NEW MENTAL HEALTH CARE BILL, WHICH WILL BE TABLED IN THE MONSOON SESSSION OF PARLIAMENT. IT IS ALSO CHARTING A MENTAL HEALTH POLICY.

VIBHA VARSHNEY AND **KUNDAN PANDEY** ANALYSE WHETHER THE EFFORTS WILL HELP IMPROVE THE LOT OF INDIA'S MENTALY ILL

For the past three years, every month Jagat Ram travels from Hapur district of Uttar Pradesh to Delhi's Institute of Human Behaviour and Allied Sciences (IHBAS) to fetch medicines for his younger sister. She suffers from depression, the most common mental illness in the country. "It all began at her in-laws' place. She used to complain of torture," recalls the 35-year-old. In 2007, after losing her newborn she slipped into shock. It was a crushing blow to her already shaky marriage. She became quiet, stopped doing household chores, did not care for her appearance and even stopped bathing. Instead of getting her treated, her in-laws would accuse her of acting out to garner attention. Her condition continued to deteriorate. That's when Jagat Ram forcibly brought her back home. For almost a year, he spent money on costly private treatment in his native place. But she showed no sign of improvement. It was by chance that the family brought her to IHBAS. She is now on the road to recovery. "We now have to keep her away from negative thoughts," Jagat says. "Though I still spend money on travel and take frequent leaves from office, it's worth it."

But Jagat Ram's sister is one of the few people who have found their way to a premier institute like IHBAS or expensive private care. The rest—in the absence of government data, IHBS director Nimesh Desai says one in 10 people in the country could be suffering from diagnosable mental problems—depend on a nearly defunct National Mental Health Programme or find relief in faith healing.

About 900 km away, in a tribal village in Jhabua district of Madhya Pradesh, 19-year-old Sanju, too, displays symptoms of depression. His father, Ratan Singh believes he is under the spell of evil spirits. Sanju was fine till two years ago. Then his behaviour suddenly changed. He stopped responding to calls and did not even care for himself. He would cry for no reason. In the past two years, Ratan Singh and his wife have travelled several times to the Baba Dongar temple atop a hill, hoping that god would cure Sanju. They also promised to sacrifice cocks at the temple if Sanju showed improvement. Though the boy is yet to show any sign of improvement, the couple dared not break their promise. Baba Dongar is their only hope. When asked why he does not take Sanju to a doctor, a bewildered Ratan Singh says Sanju does not have any health problem. And he is not the only one to believe so. Kalu Singh Bamanai, a photographer of Samni village who earns his livelihood by taking photos of the pilgrims at the temple, says every day five to 10 families, even educated ones, visit the shrine, hoping their mentally ill relatives would be cured.

When the Centre launched National Mental Health Programme (NMHP) in 1982, one of its objectives was to allay such ignorance and integrate mental healthcare in general healthcare by introducing mental health centres in each district. These centres are headed by psychiatrists who travel to interior parts of the district and provide treatment to patients. The programme floundered. "Very few patients visit the doctor," says R K Bairagi, head of NMHP's district mental health programme (DMHP) for Sehore district in Madhya Pradesh. "While some fear social stigma, the rest are superstitious. We are planning to take the help of tantriks to bring

ANIRBAN BORA / CSE

mentally ill patients to the centre. Tantriks deal with many such patients and could be helpful to bring them here. They would perform their rituals and after that ask patients to visit the centre," he adds.

Even if it works it will be only half the solution. If people actually approach the Sehore DMHP centre it will not be able to handle the load. The Sehore DMHP centre is the only hospital, other than the Mental Hospital Indore and Gwalior Mental Hospital, to cater to the mentally ill people of Madhya Pradesh. Between 1996 and 2007, the Central government had sanctioned four other DMHP centres in Shivpuri, Dewas, Mandala and Satna districts, but all of them have become dysfunctional. Even the Sehore centre is under-staffed. "We advertised for the posts of psychiatrists and psychologists for this centre at least four times but no one responded. There is shortage of psychiatrists and psychologists in the state because there are no PG courses on these subjects in any of the six medical colleges of the state," says Bairagi, who shuttles between Sehore and his hometown Bhopal, about 50 km away. He comes to the centre only twice a week.

Secretary of the Madhya Pradesh State Mental Health Authority, R N Sahu, says DMHP failed in the state because it is not a priority for the authority. The money sanctioned for Satna and Jabalpur centres was returned to the Centre because the district authorities were not interested in the programme. "I had sent proposals to revive the defunct centres and begin DMHP in five new districts more than a year ago. But the proposals were never forwarded to the Centre," he says.

The situation is no better in other states. The programme has made little headway in the past three decades.

"Although DMHP is supposed to be active in 123 districts (of 652 districts), it is barely functional in most districts," states the mental health policy group, established in May 2011 to create a mental health policy for the country and provide recommendations to improve DMHP in the 12th Five-Year Plan. The group submitted its report in June 2012. "…barring islands of good performance, the DMHP is yet to achieve its objectives," says the group. Inconsistent fund flow, lack of trained staff, lack of coordination between departments and non-availability of psychotropic drugs and psychological treatment are plaguing the programme. The group's report indicates that states are reluctant to take over funding of DMHP. As per the guidelines, the Centre will fund DMHPs for five years, after which the respective state governments shall take over the programme.

Rahul Shidhaye, clinical psychiatrist working with advocacy group Public Health Foundation of India, points out another flaw in the programme design. "NMHP is the only public health programme in the country where finances are routed through the Directorate of Medical Education," he says. "The deans of medical colleges are busy training psychiatrists and are not concerned about public healthcare whose foundation rests on awareness and reduction of stigma."

INDIA HAS NEVER UNDERTAKEN A MENTAL HEALTH SURVEY. HEALTH EXPERTS SAY ONE IN EVERY 10 PERSONS IN THE COUNTRY COULD BE SUFFERING FROM MENTAL ILLNESS

In the 12th Five Year Plan, the government plans to redesign the programme and expand it to all the districts in the country. But will it be effective given that India has never undertaken an official mental health survey?

Several analysts are sceptical. A similar effort in 2002 to revamp NMHP and expand it to 22 districts had significantly changed the scope of the programme. "The new policy reduced emphasis on access to services and community participation (which were the prime aim of the 1982 policy) and moved towards provision and distribution of psychotropic medication," say Sumeet Jain and Sushrut Jadhav from University College London, the UK, in a paper published in March 2009 issue of *Transcultural Psychiatry*. The authors suggest that the authorities revamped the programme without analysing the problems that were ailing NMHP. "...there is no indication of who was involved in this (consultation) process and what resulted from it," it notes.

The study holds lessons for Union Ministry of Health and Family Welfare, which plans to revamp its mental healthcare system. It has drafted a Mental Health Care Bill to replace the Mental Health Act of 1987. The Cabinet cleared the Bill on June 13. In all probability, the Bill will be tabled in Parliament in the Monsoon Session, beginning on August 5, and will be cleared. To facilitate its implementation the ministry, for the first time, is charting a mental health policy.

1912
Indian Lunacy Act comes into existence

1954
All India Institute of Mental Health comes into being; later renamed National Institute of Mental Health & Neurosciences

1974
Srivastava Committee recommends to include mental healthcare in community health workers' scope of work. It is ignored

1975
Training of general practitioners in psychiatry started at NIMHANS

1976
Programme of Community Psychiatry launched at NIMHANS

1976-81
India undertakes the first pilot study at Raipur Rani in Haryana along with WHO for strategising how to extend mental healthcare

1980-86
Pilot experiment extends to Bellary district in Karnataka

BIOLOGICAL REALITY OF MENTAL ILLNESS

There is no single cause that triggers mental illnesses. There are several factors, right from genetic inheritance and exposure to brain-damaging chemicals to conditions that beset people, such as work pressure, death of loved ones or even romantic rejection, which can trigger dysfunction of the brain and lead to mental disorders.

Generally, it is considered that the dysfunction occurs due to problems with neurotransmitters, or chemicals that help neurons in the brain communicate. For example, the level of the neurotransmitter serotonin is lower in individuals who suffer from depression. Similarly, disruption in neurotransmitters, dopamine, glutamate and norepinephrine, is linked to schizophrenia. Such understanding helps in the development of drugs to treat the problem. Biological psychiatry is now an established branch of psychiatry and uses imaging techniques like psychopharmacology and neuroimmunochemistry to pinpoint the problem. Using these techniques, researchers, in the past five years, have identified genes that influence susceptibility to five common psychiatric disorders, including bipolar disorder. Their finding was published in medical journal *The Lancet*. Using the technology, researchers at the National Institute of Mental Health in the US are developing a classification system that would help differentiate the structure and function of a mentally ill brain from that of a healthy one. This will help researchers understand why a traumatic event leads to post-traumatic stress disorder, neurology of hallucinations and how drug addiction rewires the brain.

There is still a long way to go. Scientists are nowhere close to understanding the brain the way they understand heart, kidneys and other parts of the body.

ECCENTRIC SIDE OF INDIA

Schizophrenia
Person suffers from delusion, hallucination

3,737,481

Mood disorders
Include depression and bipolar disorder, marked by alternating episodes of mania and depression

19,933,232

Cannabis users
Those addicted to intoxicating hallucinogenic drugs

9,966,616

Mental retardation
A condition due to incomplete growth of brain, characterised by impaired cognitive, language, motor and social abilities

1,245,827

Child, adolescent disorders

30,896,510

Geriatric disorders
Mental illness that onsets with aging

3,089,651

Dementia
Deterioration of an invidividual's intellectual, emotional and judgemental abilities; can occur with aging or injury to brain

1,893,657

Common mental disorders
Describe a state of deeper psychological distress; includes anxiety disorders, dissociative disorders, phobia and somatoform pain or acute false pain

24,916,540

Epilepsy
Neurological disorder with convulsive seizure

11,212,443

Alcohol dependency*
A pattern of compulsive alcohol use

12,458,270

Opiate users

2,491,654

Source: Estimates for 2015, made using 2001 population by the National Commission on Microeconomic Health
* This group does not include hazardous alcohol users, whose number would be approximately 240 million

PHOTOGRAPHS: SOUMIK MUKHERJEE / CSE

1987
National Mental Health Act is introduced

1993
National Mental Health Act comes into force, replaces Lunacy Act

1996-97
District Mental Health Programme (DMHP) is launched in four districts

2001
WHO focuses on mental health; introduces World Health Day theme based on mental health

2007-08
DMHP expands to 123 districts

2010
Government prepares Mental Health Care Bill

April 5, 2011
Government orders a 13-member policy group to frame mental health policy

2012
WHO Executive Board adopts a resolution on coordinated health and social sector response to mental health problems

June 13, 2013
Union Cabinet clears the Mental Health Care Bill

A JOURNEY IN THE DARK

Poverty, gender discrimination, alcohol use, stress of modern life, conflicts and natural disasters—most of the identified risk factors for mental illness are common in India. But in the absence of an official mental health survey, there is little data on the number of people who suffer from the illness.

The most reliable and often quoted figure that provides some sense of prevalence of the illness is a report by the National Commission on Macroeconomics and Health (NCMH) published in 2005. According to the report, at least 6.5 per cent of the Indian population—more than 80 million people—suffer from serious mental disorders, such as schizophrenia, bipolar disorder and obsessive compulsive disorder, with no discernible rural-urban difference. The share of mental illnesses is 8.5 per cent of the total burden of diseases in the country. These figures will grow substantially, with increasing population, the report suggests.

Very little direct evidence is available at community levels. But the few that are available provide a worrying picture. An analysis of data from the Chennai Urban Rural Epidemiology Study, published in *PLoS One* on September 28, 2009, shows 15.1 per cent of people in urban and rural areas of Chennai suffer from depression. The study found that the problem is more pronounced among women and people from low-income groups. More than 16.3 per cent women suffer from depression compared to 13.9 per cent men. About 19 per cent people in low-income groups are depressed.

Analysts say the figures are merely an indication of a deep abyss because the studies often take into account only those who have at some point of time visited a doctor or have acknowledged their problem. Given the stigma attached to mental illness, very few people are open to diagnosis and treatment. A joint publication by the National Human Rights Commission and the National Institute of Mental Health and Neurosciences in 2008 notes that "morbidity due to mental illness is set to overtake cardiovascular diseases as the single largest risk in India by 2010".

Adverse effects of these illnesses are rising in the country. According to WHO, depression and other mental illnesses are the major causes behind suicide. Data from the National Crime Record Bureau shows there has been a rise in the cases of suicide in the country. More than 135,000 people committed suicide in 2012 alone—a 22.7 per cent increase from 2002 (see 'Depressing growth').

DEPRESSING GROWTH

Suicide cases in the country have increased by more than 22% in the past decade

2003	110,851	10.4
2004	113,697	10.5
2005	113,914	10.3
2006	118,112	10.5
2007	122,638	10.8
2008	125,017	10.8
2009	127,151	10.9
2010	134,599	11.4
2011	135,585	11.2
2012	135,445	11.2

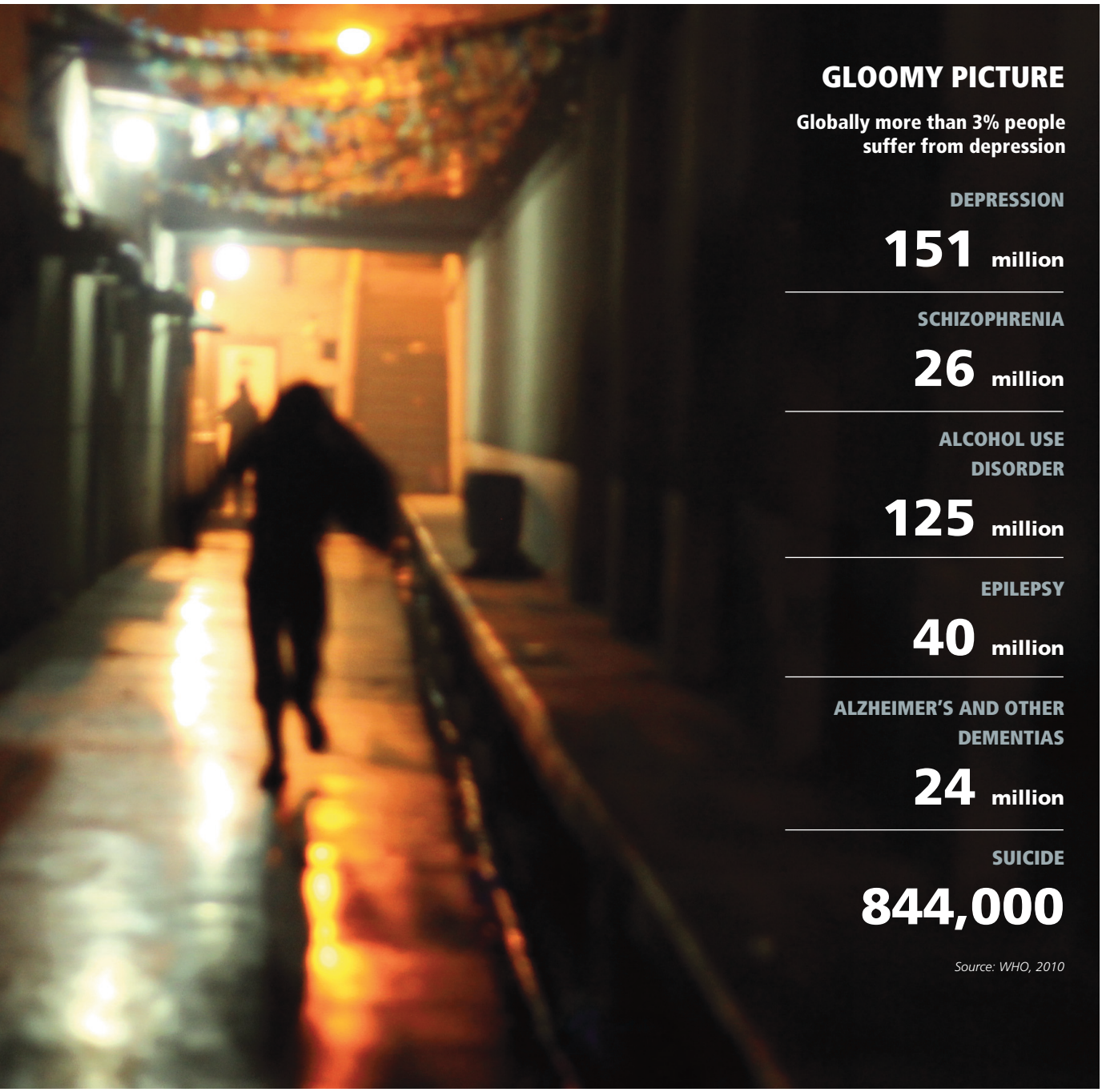
Source: National Crime Record Board

Number of suicides

Rate of suicides (%)

In recent years, the list of risk factors for mental illnesses has become longer. Increasing intensity and frequency of natural disasters have been identified as major contributors to mental illnesses, especially in children and adolescents. A study published in peer-reviewed journal *BMC Psychiatry* in 2007 shows even a year after the super cyclone ravaged coastal Odisha in 1999, almost one-third of the children could be diagnosed with post traumatic stress disorder (PTSD), a severe mental condition.

It is relevant to note that mental disorders are a risk factor for many noncommunicable diseases.



GLOOMY PICTURE

Globally more than 3% people suffer from depression

DEPRESSION
151 million

SCHIZOPHRENIA
26 million

ALCOHOL USE DISORDER
125 million

EPILEPSY
40 million

ALZHEIMER'S AND OTHER DEMENTIAS
24 million

SUICIDE
844,000

Source: WHO, 2010

According to a 2012 report by WHO, more than 3 per cent of the world's population suffers from depression, which predisposes people to heart diseases and diabetes. Those with depression and schizophrenia have 40 per cent to 60 per cent greater chance of dying prematurely either by committing suicide or from unaddressed health problems such as cancer, cardiovascular diseases, diabetes and HIV infection. Noncommunicable diseases also increase the likelihood of depression, notes the report. This holds a threat for India where noncommunicable diseases are fast taking over communicable diseases.

The 2010 World Economic Forum Report warns that mental illness poses the second most severe threat to the global economy. In view of the potential harm that mental illnesses can cause, governments worldwide are gearing up to set up a system to tackle the problem. India is under tremendous pressure, both from international forums and from civil society at home, to contain the illnesses. The government believes this can be done only by introducing the Mental Health Care Act and the Mental Health Policy.

But are these interventions robust enough to ensure that the mentally ill receive treatment as well as care?

HAVE A CARE

Thirty-year-old Tamanna lives a life of rejection. Last year, her husband and his family brought her to Indore Mental Hospital. Doctors diagnosed her with bipolar disorder and admitted her to hospital. Within a couple of months, they declared her healthy and asked her family to take her back home. But no one wanted to take her back. Tamanna kept writing to her family for six months, but there was no response. Even her mother did not respond. Finally, the hospital administration had no choice but to shift Tamanna to a nearby shelter home with due permission of the Chief Judicial Magistrate.

Tamanna is not the only one who has been ostracised because of mental illness. A warden at the hospital, who did not wish to be named, says she has witnessed at least 12 such cases in the past two years where family members refused to take back their wards even after doctors certified complete recovery. More often than not women face institutionalisation and desertion. Indore Mental Hospital alone has more than 40 women inmates compared to 20-odd men.

More than 50 per cent of patients admitted to a mental hospital often end up staying there for five years or more. The most unfortunate aspect of this problem is that these patients have been in the hospital for years not because of treatment-related reasons but because their families have abandoned them. Prolonged hospitalisation has further impaired their socio-vocational skill, points out the National Human Rights Commission (NHRC) in its report submitted to the Supreme Court in February this year. NHRC has been reviewing mental health institutions in the country since 1997. That year the apex court had asked it to monitor mental health hospitals at Agra, Ranchi and Gwalior following complaints of human rights violation.

At the root of this apathy towards the mentally ill is the Mental Health Act of 1987, which takes away all rights of mentally ill people and treats them as someone who is dangerous and, therefore, requires institutional confinement. They are

Crumbling infrastructure

Available psychiatrists	**3,800**
Requirement	**11,500**
Clinical psychologists	**898**
Requirement	**17,250**
Psychiatric social workers	**850**
Requirement	**23,000**
Psychaitric nurses	**1,500**
Requirement	**3,000**

Source: Lok Sabha reply, February 22, 2013

When to see a doctor

- Marked personality change
- Inability to cope with problems and daily activities
- Strange or grandiose ideas
- Excessive anxiety
- Prolonged depression and apathy
- Marked changes in eating or sleeping patterns
- Extreme highs and lows
- Abuse of alcohol or drugs
- Excessive anger, hostility or violent behavior

Source: American Psychiatric Association

not allowed to take decisions about their lives, their healthcare and property. Even until a decade ago—the Mental Health Act came into force only in 1993—India was following the archaic Indian Lunacy Act, 1902. Framed during the colonial period, the Act considered the mentally ill as dangerous to society and aimed at protecting the public from them. Analysts say the Lunacy Act is largely responsible for shaping the apathetic attitude of society towards the mentally ill.

The Union health ministry claims that the Mental Health Care Bill and the Mental Health Policy will restore the rights of the mentally ill. But an analysis of the draft bill suggests there is a long way to go. As of now, it appears that the steps taken are only to comply with mounting international obligations.

In 2006, India ratified the UN Convention on the Rights of Persons with Disabilities, which aims at ensuring equality and autonomy for the people who have long-term physical, mental, intellectual or sensory impairments. With this, it became necessary for India to change its legal framework. WHO also suggested its member states to ensure social care services to the mentally ill in community settings. These were daunting tasks, requiring a huge upgrade in the existing mental healthcare system. Being a member-state of the UN, India has to abide by the resolution. In 2010, the Union health ministry proposed the Mental Health Care Bill. A year later, it established a

Don't see mental health problems as disorders but as day-to-day stress. If caught early enough all mental illnesses can be treated

OM PRAKASH
Associate professor of psychiatry, Institute of Human Behaviour and Allied Sciences, Delhi

WHAT'S IT LIKE TO HAVE PANIC ATTACKS

A survivor shares his story

I was moving up in the world. As an ambitious young business promoter in the healthcare industry, I had a bright career ahead of me. I was happily married for eight years and was blessed with two beautiful daughters. But at the age of 32, I suddenly started getting panic attacks. The first time I had the attack, I was jolted awake in the middle of the night, doused in sweat. There was an ice cold sensation in my chest. An unknown fear overpowered me. My wife, with the help of a neighbour, took me to a hospital in Gurgaon. The doctors overruled any cardiac or other related problems. But the sensation kept getting worse. My doctor friends asked me to see a psychiatrist. I was lucky enough to be educated, have disposable income and time to get help. A young psychiatrist in Gurgaon started my treatment with anti-depressants and counselling. But my friends in the healthcare industry discouraged me from anti-depressants. They said a headstrong person like me could not be depressed. I had always felt the same. Perhaps I was wrong; they were wrong. Although what triggered my panic attack remained a mystery, I started feeling better. I thought I had recovered and stopped medication on my own. Over the next few months I changed job and moved to Ahmedabad. New challenges and more salary kept me busy. Then one night, I again felt the cold sensation in my chest and was sweating profusely. I rushed to a physician. Based on my history, he advised me to see a psychiatrist. I was back to square one.

My new psychiatrist was a renowned one. On an average, he was seeing 100 patients a day. He did not have time for me. His juniors took my details and prescribed medication, which I disliked. So I changed the doctor. I told him I want to reduce my dependence on medicines. He prescribed me fewer medicines and advised me to go to a psychotherapist.

A psychotherapist is not a doctor, but a trained professional who helps increase an individual's sense of wellbeing through therapeutic interaction and counseling. My 50-year-old psychotherapist has a couch. I lie down and share all my fears, feelings, daily experiences and talk for an hour. I feel relaxed and stress-free after the session. There are days when I would look down from my apartment on the 9th floor and get thoughts of committing suicide and get paralysed. Will I jump from this window? Can I control my legs? Should I seek help of my wife? The next day I analyse my feelings with my psychotherapist. She listens to me and guides me about the thoughts. I am in a process of re-discovering myself. She is my main stay these days to fight depression and feel better.

Every week I attend three to four sessions with her. Practicing yoga, pranayama and walking gave me some relief but only psychotherapy has helped me.

group for writing the country's first mental health policy and redesigning the failing National Mental Health Programme (NMHP). This was just in time because in 2013 WHO passed a resolution at the 66th World Health Assembly. The resolution says member states, especially low- and middle-income countries, where needs are high and resources inadequate, will have to increase service coverage for severe mental disorders by 20 per cent and reduce suicide rates by 10 per cent by 2020. India was at the fore front, asking for these changes.

An evaluation mechanism has to be built in the mental health policy. Absence of evaluation is as good as not having a policy

RAHUL SHIDHAYE
Clinical psychiatrist, Public Health Foundation of India

Building a system without policy, infrastructure

The Mental Health Care Bill provides a definition for mental illness for the first time. Mental illness is "a disorder of mood, thought, perception, orientation and memory which causes significant distress in a person or impairs a person's behaviour, judgement and ability to recognise reality or impairs that person's ability to meet the demands of daily life", notes the draft bill. It thus recognises mental conditions associated with abuse of alcohol and drugs as mental conditions and gives more rights to the mentally ill.

To ensure that the rights are not violated, the Bill envisages a mental health review commission at the Centre and state-level mental health review boards. The review bodies will have quasi-judicial power and will be the first point of interaction for persons with mental illness or their representatives in case their rights are violated. To address the needs of the families, caregivers and mentally ill people who are homeless, the Bill provides for setting up of mental health authorities both at the state and Central levels. They would act as administrative bodies for the mental healthcare system.

The Bill also decriminalises suicide attempts by the mentally ill, meaning attempt to commit suicide by a mentally ill will not be subject to any investigation or prosecution. Both doctors and activists point out that the proposed legislation, however, fails to address several crucial issues that plague the mental healthcare system in the country (see 'Can rights sans care help?'). Even the prescribed rights would fail to deliver unless the government prepares the mental health policy.

While the Bill is on the verge of getting approved by Parliament, the policy, which is crucial in implementing the Act, is nowhere to be seen. In May 2011, when the Mental Health Policy Group came into being the Union health ministry gave it a year's time to prepare the policy. Since then the group has sought six-month-long extensions twice, but not even a draft is available in the public domain.

In its submission to the Supreme Court, NHRC points out that lack of data on the country has slowed down the process of policy making. On July 8, the apex court sought response from states and the Centre on the need of a country-wide survey to realise the extent of mental illness.

Sujaya Krishnan, joint secretary with the Union health ministry who was part of national deliberations on the Bill, says the government will be able to implement the Bill even in the absence of a policy. "We will use the existing infrastructure under NMHP. The Union health ministry has started the process of increasing manpower and since 2011 it has added about 350 psychiatrists to the workforce. This might be a small beginning but at least we have started," she says.

The Union health ministry's own data, as revealed in a reply in Lok Sabha on February 22, 2013, however, shows an acute shortage of mental healthcare professionals in the country (see table on *p*37). Moreover, these handful of professionals are distributed unequally across the country.

A 2010 analysis by Chennai and UK researchers, published in the *Indian Journal of Psychiatry*, shows Chandigarh, Delhi, Goa and Puducherry had a surplus of psychiatrists. Ideally, there should be one psychiatrist per 100,000 population. Chandigarh had 244 per cent surplus psychiatrists. The rest of the states and Union Territories did not have adequate number of psychiatrists. Nine states, which account for 41 per cent rural population, faced more than 90 per cent deficit. Not a single psychiatrist was there to cater to the 60,000 population of Lakshadweep.

Make the Mental Health Care Bill part of the pending health Bill. This would help reduce the stigma attached to mental disorders

ABDUL MABOOD
Director, Snehi, Delhi

The NHRC report also points out that to tackle the problem both infrastructure and manpower are in short-supply in the country.

Can rights sans care help?

The Mental Health Care Bill has failed to please both doctors and mental health activists. Analysts say the Bill provides rights to community care and independent living, but does not put the onus on the government.

Another provision that has drawn criticism from all quarters is that of advance directive. This provision proposes a legal document that tells what healthcare services a person wants in case he develops mental illness. Psychiatrists see this as an intrusion into their autonomy. Sameer Kalani, clinical psychiatrist and member of the Delhi Psychiatry Centre, says giving autonomy to the patient to decide the treatment could be a problem when the patient is seriously ill.

Another such contentious issue is a provision that reduces time for which a patient can be admitted in an institution to 30 days from 90 days. Activists say this makes sense as medicines start working within two weeks. But several psychiatrists say this provision makes the procedure of hospitalisation cumbersome. While admitting a patient, the psychiatrist and medical officer will have to inform the proposed mental health review boards within three weeks of admission. They will have to inform again if they plan to extend the patient's hospitalisation. Bengaluru-based non-profit Centre for Law and Policy Research suggests that the bill should have banned electric shocks (electro convulsive therapy or ECT) as a form of treatment. But Kalani differs. Overall side effects of medicine are higher than that of ECT, which is used only in emergency, like if the patient is suffering from extreme suicidal instinct, extreme excitement. In such cases, ECT starts showing impact in three to four days, while the medicines show impact after three to four weeks. Instead of banning, there should be a clear-cut guideline on how and when ECT should be used, he suggests.

Akhileshwar Sahay, a patient of bipolar disorder and a member of the mental health policy group, points out that civil society should welcome the initiative. The government is at least taking some steps. Innovations can happen later.

Treatment is not all about pills

World over, there is concern over the excess dependence on medicines. "Pharmaceuticals have already changed the character of National Mental Health Programme (NHPM)," write Sumeet Jain and Sushrut Jadhav from the University College London in their paper published in March 2009 in *Transcultural Psychiatry*. They studied the role of psychotropic medication in NHPM and found that instead of being a symbol of accessibility to healthcare, the pill ends up being a method of administering a discrete treatment. "Thus, instead of empowering the community, the pill silences community voices and re-enforces the existing barriers to care," they write.

Pharma lobby influencing the mental health care system is not unique to India. In 2007, the psychiatrists and pharmaceutical company nexus in the US reportedly resulted in growing use of new antipsychotics in children. Between 2000 and 2005, the industry's payments to Minnesota psychiatrists rose more than six-fold. During the period, prescriptions of antipsychotics for children under the state's insurance programme rose more than nine-fold. In the US, six time more antipsychotics are prescribed to children and adolescents than in the UK. More than 30 million Americans take antidepressants. Another example of this unholy nexus is the recently released Diagnostic and Statistical Manual of Mental Disorders prepared by American Psychiatric Association. The manual turns even common ailments into mental illnesses. For example, it terms common experiences like grief as clinical depression, and binge eating a new category of illness. It is alleged that the manual aims at pleasing the pharma industry.

In 2012, CNN IBN revealed that a group of 11 neurologists and their families from Madhya Pradesh went on a seven-day trip to London and Scotland. According to the travel agency documentations, the trip was funded by INTAS, a pharma company based in Ahmedabad that manufactures psychiatric drugs. The doctors, travel agency and the pharmaceutical industry have denied this.

The government should spread awareness about mental illness. This would help ensure early diagnosis

R SRINIVASA MURTHY
former director, National Institute of Mental Health & Neuroscience, Bengaluru

Hospital buildings are dilapidated. At many places, there is no lighting arrangement. In the absence of proper facilities, patients are forced to defecate in the open.

But improving manpower and infrastructure alone will not help curb the rise of mental health problems.

Most mental illnesses can be controlled through care and emotional support that restores one's self esteem (see 'What's it like to have panic attacks?' on *p*39). So the new thinking is that more money should be used for outpatient treatment. WHO's Mental Health Atlas 2011 shows high-income countries have already moved ahead in this direction. Globally, 67 per cent of mental health spending is directed towards outpatient treatment. India allocates only a meagre part of its mental healthcare budget for outpatient treatment. Take Gujarat, for example. In 2003, of the ₹8,5620 lakh sanctioned for healthcare, the state allocated 0.95 per cent—₹820 lakh—for mental health. Of this, 92 per cent was spent on infrastructure and a meager ₹21.5 lakh was allocated for DMHPs. Worse, 67 per cent of this fund was spent on staff salaries and 20 per cent on medicines and supplies, points out a 2009 report by Basic Needs, an international charity.

"It is possible to treat over 99 per cent of the mentally ill people without hospitalising them. Outpatient treatment is preferable because the conditions in a mental hospital are often abominable," Nimesh Desai, director IHBAS, said at the National Seminar on Perspective on Mental Illness in India held in Chennai in July 2010. With high allocations to the programme under the 12th Five Year Plan, there is an opportunity for the country to invest more in community care.

Involve communities, create awareness

Down To Earth spoke to experts on how the mental health policy can be made robust.

Rahul Shidhaye, a clinical psychiatrist working with non-profit Public Health Foundation of India, says the key lacuna in the existing system is lack of organisation of services. The public sector is small and the private sector provides most of the services. Therefore, the policy should focus on strengthening the public healthcare system. Simultaneously, it should regulate the role of private mental healthcare providers. Dependence on psychiatrists should be reduced as in the case of TB programme where not all diagnosis and treatment are done by specialists. Like HIV/AIDS programmes, mental healthcare system needs counsellors. The evaluation mechanism has also to be built in the policy, he adds.

G Gururaj, head of the epidemiology department at National Institute of Mental Health and Neuroscience (NIMHANS), a premier institute for mental health sciences in Bengaluru, says focus should be on implementing the Bill and the policy. "Strength of India lies in its strong community structure where most of the mentally ill are taken care of by their families," says Nimesh Desai of IHBAS. This aspect needs to be strengthened, he suggests. Abdul Mabood, director of Delhi non-profit Snehi, suggests instead of devising a separate mental health policy, the government should make it part of the pending national health policies.

Agrees R Srinivasa Murthy, former director of NIMHANS. "We need to make mental healthcare accessible, affordable and acceptable to the patient. For this he suggests a three-pronged approach: involve community, integrate mental healthcare with general healthcare system so that mental illness is dealt along with other illnesses, and bring about a change in the attitude of specialist doctors who are not willing to accept that non-specialists could provide care.

"The existing system is controlled by the pharmaceutical lobby and the private sector lobby," says Murthy (see 'Treatment is not all about pills'). Instead the government should focus on spreading awareness about mental illness. Unfortunately, India does not have a diagnostic manual of mental disorders. "People should know what to do when they are sick. For creating awareness the government should use standard methods such as posters, radio and TV shows, street plays and social media. Mental illness-related information can be made available in the form of questionnaires, narratives or life stories of survivors. Networks of survivors can help patients combat the illness. Murthy says awareness would go a long way in reducing social stigma and ensuring early diagnosis. Remember, early diagnosis is the key to fight mental illness. ■

(Names of the patients and their relatives have been changed)
With inputs from Snigdha Das